MEDICAL CLAIM FORM

KCDRB Form 5

LEOFF-I Employer's Statement: Claim for Reimbursement of Medical Expenses

(To be completed by LEOFF-1 employer)

Please mail this form with any relevant accompanying documentation to King County Disability Retirement Board, The Chinook Building CNK-ES-0240, 401 Fifth Avenue, Seattle, WA 98103-2333. If you have questions, call 206-263-6394, or 206-684-1556 (call center).

Section I. Employment Status of LEOFF-1 Claimant

LEOFF-1 claimant: _____

Postion/title: _____

LEOFF-I employer: _____

Active duty: ☐ Date hired: _____

Currently on disability leave? ☐ Yes ☐ No

Date started disability leave: _____

_____

Is this medical claim related to the disabling condition? ☐ Yes ☐ No

If "No", explain: _____

_____

Retired from duty: ☐ Date hired: _____

☐ Service retirement ☐ Disability retirement

Section II. Insurance Status of LEOFF-1 Claimant

(to be completed by human resources/benefits representative)

LEOFF-1 claimant's medical insurance currently includes:

1. Enrollment in health plan offered by employer ☐ Yes ☐ No
   If "Yes", name of plan: _____
   If "No", explain: _____
2. Coverage under spouse's insurance ☐ Yes ☐ No
   If "Yes", state name of spouse's insurance carrier: _____
3. Medicare, Part A ☐ Yes ☐ No
   Medicare, Part B ☐ Yes ☐ No
   If "No", explain: _____
4. Claim submitted to you within six months of initial billing? ☐ Yes ☐ No
   If "No" explain: _____

All billing statements, applicable insurance Explanation of Benefits, and treatment plan (when required under Board rules) are attached. The total dollar amount sought herein reflects only the balance outstanding after all other sources of reimbursement have been exhausted.

Signed: _____ Date: _____
Human resources/benefits representative

Revised 1/08

Section III. Supervisor's authorization

(to be completed by the LEOFF-1 member's immediate supervisor)

1. Do you have reason to believe the medical services and expenses claimed ☐ are not necessary, ☐ are not reasonable, or ☐ do not comply with Board rules? (Check those applicable.) For more information, see Rule 8.11(c).

Explain: _____

_____

_____

2. Do you feel you need board approval to process and pay this claim?

Explain: _____

_____

_____

3. Do you believe that the claimant could have received reasonably equivalent services through a pre-paid health care plan available to the claimant? (See KCDRB Form 6.) ☐ Yes ☐ No

Explain: _____

_____

_____

Signed: _____ Date: _____

LEOFF-1 supervisor

Title: _____

The King County Disability Retirement Board for LEOFF-1 will only accept original signed and dated claim forms. If you are concerned about privacy, do not e-mail personal information or a copy of this completed form to the Board – your privacy over the Internet cannot be guaranteed.